King County

# VETERANS AND HUMAN SERVICES LEVY
# 2008 STRATEGY AREA ANNUAL REPORTS

**Activity 2.1(b-1)**
**Expanded outreach and engagement to those who are Homeless in South King County**

## OBJECTIVE

The Levy's investment in Strategy 2 focuses on ending long-term homelessness through a variety of interventions including identification, outreach, prevention, housing, supportive services and education. The objective of Activity 2.1 of the Veterans and Human Services Levy is to identify, engage and house people who have been chronically homeless over the long term. This specific sub-activity, 2.1(b-1), is focused on those who are homeless in South King County.

This report is one of four to address this strategy. The other three include a proposal for development of a county-wide database to identify high utilizers of public safety and emergency medical systems (Activity 2.1(a-1)), a report on services to Seattle utilizers of the Sobering Center (Activity 2.1(a-2), and a report on the implementation of the mobile medical van (Activity 2.1(b-2)) that provides medical services to homeless in South King County. This report addresses the plan to enhance outreach and engagement of homeless people in South King County. Strategies outlined in this report were reviewed by the Levy oversight boards in 2007.

## POPULATION FOCUS

This program is focused on adults in South King County who are homeless, particularly on those who have been homeless for a long time, and who typically have a range of mental health, substance abuse and other serious problems.

## PROGRAM DESCRIPTION

This program is implemented by Sound Mental Health. Levy funding has been used to add two additional outreach workers to the existing PATH (Projects for Assistance in Transition from Homelessness) team. The outreach team identifies and engages people who are homeless throughout South King County, finding people in such places as feeding programs, shelters, parks, libraries, encampments and through the **mobile medical van**, which became operational in late 2008.

The partnership with the **mobile medical van** allows a medical service provider to provide a face-to-face introduction between a person who is homeless and an outreach worker, who then can begin the engagement process. Outreach is particularly important for this population because those who have been chronically homeless, especially those with serious disabling conditions and/or long term homelessness, often have difficulty finding or accepting the services and care they need. This hesitation may be related to fear, lack of awareness, ambivalence, loss of hope, and barriers presented by the system itself.

Outreach workers provide an entryway to services and safety, serving as a bridge between the streets and a more stable life. Outreach workers engage people who are homeless, slowly gain their trust, and support them in accessing the services and housing they need. Connection to housing and housing stability is the ultimate goal. Other positive outcomes include enrollment or reconnection with the mental health system, enrollment in benefits, such as veterans' benefits or social security, and connection with a primary health care provider.

## PROGRESS DURING 2008

Sound Mental Health was awarded a contract to provide the services described above. Levy-funded services began on October 1, 2007.

| Agency | Veterans Funds Awarded | Human Services Funds | Total Levy Funds Awarded (07-08) |
|---|---|---|---|
| Sound Mental Health | 64,200 | 149,800 | 214,000 |
| | | | |
| **Total** | **64,200** | **149,800** | **214,000** |

## SERVICES PROVIDED

This project has had a number of challenges in its implementation. Start up activities began in the final quarter of 2007, and Sound Mental Health began activities in the first quarter of 2008. However Sound Mental Health experienced difficulties in hiring qualified staff, and because of this reduced staffing, was unable to meet contract goals until the last quarter of 2008. Funding for 2008 was reduced because of this delay.

The project is now fully operational and making good progress. The mobile medical van has been an exciting addition to the project, both because of the direct services it provides people in need, but also as a mechanism for outreach.

The team will need to continue to address the issue of caseload. Working with people who have been chronically homeless is very time consuming. Building trust takes time, and requires a consistent presence. Outreach case managers must search people out, and expect that often they will not show up at an agreed place and time. In addition, these clients have a multitude of needs to be addressed, and they need support throughout the process. The contract with Sound Mental Health calls for an ongoing caseload of 15 clients to one outreach case manager, but case managers are currently exceeding this level. The team will need to find a balance between ongoing outreach to new clients, and sufficient time to address the needs of current clients.

**Number Served.** During 2008, the program served a total of 276 clients. For those for whom demographic information is known, 98% were homeless in South King County. Outreach case managers keep an outreach log that documents the number of encounters with potential clients. Only those who develop some ongoing relationship with the case manager become “clients,” and have a case file opened. Outreach case managers work to identify and engage potential clients at a variety of sites throughout King County. They work with clients to build trust, determine needs and help them address these needs, including enrollment in benefits such as SSI, connection with mental health and/or chemical dependency treatment, connection with medical primary care, and finding housing. Staff will be conducting an on-site monitoring visit of this program in the fall of 2009.

| Total Served | East | North | Seattle | South | Unknown |
|---|---|---|---|---|---|
| **276** | 2 | 0 | 1 | 202 | 71 |

Note that the program does not collect demographic information except for those with an ongoing engagement with the program.

**Living Situation.** All of those served by the project were homeless. Again, however, this was only verified with those who had longer engagement with program staff.

| Living Situation | |
|---|---|
| Homeless | 138 |
| Not Homeless | 0 |
| Unknown | 138 |

**Age Group.** Most of those served who provided information ranged from 35 to 59 years old.

| Age Group | |
|---|---|
| 0 to 5 | |
| 6 to 10 | |
| 11 to 13 | |
| 14 to17 | |
| 18 to 34 | 21 |
| 35 to 59 | 130 |
| 60 to 74 | 4 |
| 75 to 84 | |
| 85 and over | |
| Unknown | 121 |

**Gender.** For those about whom demographic information was collected, men outnumbered women by a ratio of two to one.

| Gender | |
|---|---|
| Male | 115 |
| Female | 40 |
| Unknown | 121 |

**Veteran Status.** Eleven veterans are known to have been served. The actual number of veterans may be significantly higher, but demographic information was collected only from people who had a longer engagement with staff.

**Outcomes.** For this strategy, the measurable indicator is the number of clients who achieve at least one of the following: improvement in their housing stability, enrollment in primary health care, enrollment in chemical dependency treatment, enrollment in mental health services, or increase in income. Through December 2008, 126 clients experienced a successful outcome as measured by at least one of these measures.

## SUCCESS STORY

**"Sally,"** who is in her mid-50's, lived with a man who was violent and unpredictable, especially when he drank. She stayed with him because she needed his protection at the encampment in Federal Way where they had been living for the last two years.

Sally receives a GA-U benefit of $339 per month, and, each month, would use her check to pay for a motel room for a few days of shelter before returning to the encampment.

Sally first came to the mobile medical van in November 2008 with a number of chronic health problems. She had also been a victim of domestic violence and was suffering from depression. The mobile medical van team referred Sally to an outreach case manager. She was offered mental health services and placed on a waiting list for the Housing First program.

Housing became available in January, but Sally declined when she found she would have to have a roommate. An outreach case manager continued to maintain contact and provide support, checking in with her at a feeding program she regularly attended.

In March, the outreach case manager saw Sally once again at one of the mobile medical van sites. Sally came over and said, "I'm ready to take that apartment. I've got to get out of the encampment; that guy is just too violent and I need more help." She added that she was having serious medical problems and wanted to take care of them, and also wanted to start addressing her mental health issues. The following day, the outreach case manager completed the paperwork with her. Sally moved into her new apartment within the week.

Sally is typical of many of the homeless individuals encountered by the outreach team and the mobile medical van staff. It took the time, consistency, and compassion of the team to gain Sally's trust and, ultimately her willingness to accept services and housing.

## FOR MORE INFORMATION

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